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Shyla Noelle Herndon-Dye

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Walden University
2026

Executive Summary: Staff Education Project

LGBTQ+ Cultural Competency Training for Mental Health Care Workers

by

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BSN, University of Maryland School of Nursing, 2019

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Summary

The purpose of the staff education project was to address a noticeable gap in training regarding lesbian, gay, bisexual, transgender, and queer (LGBTQ+) cultural competencies for the multidisciplinary mental health care workers of an inpatient child and adolescent psychiatry unit. LGBTQ+ individuals commonly encounter discriminatory barriers to care, resulting in mental health disparities and medical distrust; thus, mental health care workers must engage in professional allyship and improve their capability to sufficiently care for this population. The practice question that guided this project was the following: Will a staff education program designed to educate multidisciplinary mental health care workers on LGBTQ+ cultural competencies improve staff knowledge, attitudes, and clinical preparedness, as evidenced by an increase in Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) scores? With the LGBT-DOCSS instructions and IBM SPSS statistical software, a paired *t* test was used to analyze the mean differences between 23 participants' presurvey and postsurvey results. There were statistically significant mean differences between the presurvey and postsurvey LGBT-DOCSS scores, as well as statistically significant mean differences for the subscales of Knowledge, Attitudes, and Clinical Preparedness ($p < .05$). These results imply that the LGBTQ+ cultural competency training effectively facilitated a more knowledgeable, inclusive, and clinically prepared workforce for LGBTQ+ patients. It is recommended that a similar LGBTQ+ cultural competency training be implemented across all health care settings at regular intervals, educating all staff members of each setting to ensure equitable, high-quality, and positive health care experiences for the LGBTQ+ community.

Background

Cultural competence consists of the knowledge, attitudes, and skills necessary to respectfully navigate another person's cultural context and perspectives, and has been evidenced to promote health equity for marginalized groups (Bass & Nagy, 2023). The lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) community experiences a high prevalence of social, political, and structural barriers to quality health care, all of which contribute to medical distrust and health disparities (Hoffman et al., 2022; Yu et al., 2023). At the time of the current project, the practicum site did not provide cultural competency training regarding the LGBTQ+ community for health care workers, and the existing generalized cultural education did not sufficiently encompass LGBTQ+ terminology, health disparities, or affirming care practices. Health care workers who are unknowledgeable and clinically unprepared to care for the LGBTQ+ population may fail to provide high-quality or patient-centered care by making biased assumptions, using discriminatory or offensive language, feeling discomfort discussing gender identity and sexual orientation, being unfamiliar with LGBTQ+ lived experiences, and experiencing difficulty advocating for LGBTQ+ patients (Bass & Nagy, 2023; Borcherding et al., 2025; Cervone et al., 2021; Schweiger, 2025). Failure to provide trauma-informed LGBTQ+ cultural competency training to health care workers would be a great disservice to the patient population by permitting the continuance of systemic injustices and negative patient experiences (Levenson et al., 2023; Rhoten et al., 2022).

The purpose of this doctoral project was to address such barriers to competent care in an inpatient adolescent psychiatry unit by implementing a staff education program intended to increase mental health care workers' knowledge, attitudes, and clinical

preparedness for LGBTQ+ patients. The practice focused question was as follows: Will a staff education program designed to educate multidisciplinary mental health care workers on LGBTQ+ cultural competencies improve staff knowledge, attitudes, and clinical preparedness, as evidenced by an increase in Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) scores?

In preparation for this doctoral project, a comprehensive literature search was performed using CINAHL, PubMed, EBSCO, and Google Scholar databases using the key search terms of “lgbtq OR lesbian OR gay OR homosexual OR bisexual OR transgender OR queer” AND “cultural competence OR cultural competency OR cultural humility OR cultural sensitivity” AND “training OR education.” This search identified 11 academic, peer-reviewed journal articles published within the last 5 years that examined the impact of an LGBTQ+ cultural competency training on the specified outcomes of knowledge, attitudes (i.e., awareness, affirmation, inclusivity, open-mindedness), and clinical preparedness (i.e., skills, practices, self-efficacy, confidence, comfortability) of mental health care workers or of multidisciplinary teams with at least one member of a mental health care specialty. As graded by the Johns Hopkins evidence-based practice model, the literature base consisted of one Level I randomized-controlled trial, seven Level II quasi-experimental studies, one Level II systematic review, one Level III systematic review, and one Level VI qualitative study (Dang et al., 2022).

In some cases, the participants demonstrated a high ceiling effect in knowledge whereas baseline values were high with little room for growth; however, in most articles, the introduction of an LGBTQ+ cultural competency training resulted in improvements in the participants’ knowledge, attitudes, and clinical preparedness, even if observed

increases were marginal from baseline (Bettergarcia et al., 2021; Bettergarcia et al., 2024; Bishop et al., 2022; Boekeloo et al., 2024; DeCesaris et al., 2024; Donisi et al., 2020; Nowaskie et al., 2024; Oblea et al., 2023; Rhoten et al., 2022; Schneidewind, 2024; Yu et al., 2023). This caveat is important to note because health care workers may be highly knowledgeable but remain insufficiently prepared. Knowledge gain alone is not predictive of behavior change, and there is often a gap between knowledge and attitudes or clinical preparedness (DeCesaris et al., 2024; Schneidewind, 2024; Yu et al., 2023).

In regard to developing and implementing the LGBTQ+ cultural competency training, several common recommendations emerged from the literature. Education should be interactive, multimodal, and multidisciplinary to optimize adult learning and team interactions (DeCesaris et al., 2024; Donisi et al., 2020; Rhoten et al., 2022; Schneidewind, 2024; Yu et al., 2023). The training methods and objectives should extend beyond knowledge gain, prioritizing practical applications and open discussions for enhanced relevance to professional practice (Donisi et al., 2020; Schneidewind, 2024). The training content should incorporate and address LGBTQ+ terminology, mental health disparities, implicit bias, social advocacy opportunities, minority stress theory, cultural humility, intersectionality, and LGBTQ+ lived experiences (Bettergarcia et al., 2021; Bishop et al., 2022; Boekeloo et al., 2024). Outcomes from the training must be evaluated with a reliable, valid, standardized tool (Bettergarcia et al., 2021). Lastly, any improvements in the facets of cultural competency can enhance the quality of and access to affirming mental health care, even if the improvements are incremental (Bettergarcia et al., 2023; DeCesaris et al., 2024; Yu et al., 2023). According to the Johns Hopkins

evidence-based practice model's Translation and Action Planning Tool, the available evidence was good and consistent with reliable recommendations (Dang et al., 2022).

Staff Education Project Development

The selected project setting was a 16-bed inpatient child and adolescent psychiatry unit located in a major metropolitan area. The target audience consisted of mental health care workers of differing roles and disciplines to ensure high-quality care across the inpatient service, including that of registered nurses, patient care technicians, behavioral health associates, social workers, a psychologist, an occupational therapist, a physician, and a nurse practitioner. Because the organization does not provide training on this particular topic, the learners' baseline knowledge and skills relied on their previous experiences and external education. Given the breadth and diversity of the target audience, the implementation phase required multiple presentations during day shifts and night shifts to accommodate staff schedules and unit needs.

The project was planned in accordance with the Johns Hopkins evidence-based practice model and associated toolkit (Dang et al., 2022), including that for organizational readiness assessments, literature appraisal and synthesis, evidence translation, and stakeholder analysis. The staff education consisted of a five-module PowerPoint presentation of course content and a handout flyer on allyship (see Appendices C and D), both of which had been adapted from educational content by advocacy agencies and evidence-based literature, and approved by members and parents of the LGBTQ+ community. The education sessions, including survey completion and opportunities for discussion and questions, were approximately 45 to 60 minutes long.

The modules of the staff education program were aligned with evidence-based objectives formulated by recommendations from the literature (see Appendix A). Module 1 included basic definitions on the spectrum of gender identity and sexual orientation, the value and inclusivity of pronouns, and the harms of outdated language and discriminatory misconceptions. Module 2 covered prominent social barriers to equitable and affirming psychiatric care and subsequent mental health disparities in the adolescent LGBTQ+ population. Module 3 introduced minority stress theory, the intersectionality framework, the trauma-informed care model, and cultural humility. Module 4 encompassed a testimonial video from LGBTQ+ individuals discussing their health care experiences and two pertinent poll results regarding reported barriers to mental health care (see North Western Primary Health Network, 2018; The Trevor Project, 2025). Lastly, Module 5 provided actionable examples of affirming practice, advocacy, and allyship. Group discussion prompts were introduced at the close of Modules 2 through 5, encouraging reflection and real-life applications of the content. An allyship handout, developed by McFarland (2024), was distributed to staff at the end of the training for further reflection.

The evaluation method consisted of pre- and postsurvey comparisons of the LGBT-DOCSS with de-identified, self-created participant codes. Participants were reassured that all responses would be anonymous, and that information would be reported to unit leadership only in aggregate at the end of the project. The chosen scale was an evidence-based, academically recognized 7-point Likert scale with 18 items, developed by Bidell in 2017, that measures health care workers' basic knowledge, personal attitudes, and clinical preparedness regarding lesbian, gay, bisexual, and transgender patients. A presurvey of the LGBT-DOCSS was administered as participants arrived at

the training, and a postsurvey was administered at the conclusion of the presentation and any participant questions (see Appendices B and E). The raw data were manually entered in an Excel sheet; then, participants' responses were scored per the instructions of the LGBT-DOCSS to calculate total mean score scores and mean subscale scores (i.e., Knowledge, Attitudes, Clinical Preparedness). The resulting data were then analyzed using IBM SPSS statistical software to evaluate statistical significance of presurvey and postsurvey mean differences using a paired *t* test and an established *p* value of $< .05$.

Results

Twenty-three ($N = 23$) health care workers of the inpatient child and adolescent psychiatry unit participated in the project. Most of the participants were 26–35 years old (34.8%) and had 10–20 years of experience (30.4%) working in health care. Over half (52.2%) of the participants had been trained in LGBTQ+ cultural competencies at some point prior to this project. The mean differences between pre- and postsurvey scores per item, per subscale, and for the overall LGBT-DOCSS are presented in Table 1. As shown in Table 2, there was a statistically significant positive mean difference between the overall presurvey and postsurvey LGBT-DOCSS scores (5.77 versus 6.45, $p < .001$). Additionally, the mean scores for the Knowledge, Attitudes, and Clinical Preparedness subscales demonstrated statistically significant increases from presurvey to postsurvey ($p < .05$). Several participants provided optional feedback at the close of the training. In terms of the most impactful or helpful component of the course, nine of the participants identified exposure to LGBTQ+ lived health care experiences and five participants identified the review of appropriate terminology and inclusive language. Lastly, three participants requested that future LGBTQ+ training be provided on a regular basis.

Table 1

Presurvey and Postsurvey Results (N=23)

LGBT-DOCSS Question	Pre-Survey Mean Score	Post-Survey Mean Score	Mean Difference
Item 1: I am aware of institutional barriers that may inhibit transgender people from using health care services.	5.17	6.70	1.52
Item 2: I am aware of institutional barriers that may inhibit lesbian, gay, or bisexual (LGB) people from using health services.	4.91	6.78	1.87
Item 3: I think being transgender is a mental disorder.	5.78	6.26	0.48
Item 4: I would feel unprepared talking with an LGB or transgender patient about issues related to their sexual orientation or gender identity.	5.61	6.04	0.44
Item 5: A same sex relationship between two men or two women is not as strong and committed as one between a man and a woman.	6.22	6.26	0.04
Item 6: I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.	5.87	6.70	0.83
Item 7: LGB individuals must be discrete about their sexual orientation around children.	4.91	5.87	0.96
Item 8: I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to cisgender individuals.	5.52	6.35	0.83
Item 9: When it comes to transgender individuals, I believe they are morally deviant.	6.39	6.83	0.44
Item 10: I have received adequate clinical training and supervision to work with transgender patients.	4.61	6.39	1.78
Item 11: I have received adequate clinical training and supervision to work with LGB patients.	4.96	6.35	1.39
Item 12: The lifestyle of a LGB individual is unnatural or immoral.	6.65	6.83	0.17
Item 13: I have experience working with LGB patients.	5.87	6.35	0.48
Item 14: I feel competent to assess a person who is LGB in a therapeutic setting.	6.09	6.30	0.22
Item 15: I feel competent to assess a person who is transgender in a therapeutic setting.	6.09	6.26	0.17
Item 16: I have experience working with transgender patients.	5.87	6.44	0.57
Item 17: People who dress opposite to their biological sex have a perversion.	6.65	6.61	-0.04
Item 18: I would be morally uncomfortable working with a LGBT patient.	6.65	6.83	0.17
Total LGBT-DOCSS Score	5.77	6.45	0.68

LGBT-DOCSS Subscale	Pre- Survey Mean Score	Post- Survey Mean Score	Mean Difference
Total Knowledge Subscale Score	5.37	6.63	1.26
Total Attitudes Subscale Score	6.18	6.50	0.32
Total Clinical Preparedness Subscale Score	5.68	6.30	0.62

Note. The LGBT-DOCSS Likert scale consisted of 7 points, with a score of 7 being the most favorable. Items 3, 4, 5, 7, 9, 12, 17, and 18 were reverse scored, per the instructions of the LGBT-DOCSS calculation instructions.

Table 2

Statistical Significance of Mean Differences per Scale and Subscale Results

	Mean Difference	*SD*	95% CI	*t*-value	*df*	*p*-value
Pre-Survey vs. Post-Survey LGBT-DOCSS Score	0.68	.55	0.44 - 0.92	5.91	22	< .001
Pre-Survey vs. Post-Survey Knowledge Score	1.26	.88	0.88 - 1.64	6.89	22	< .001
Pre-Survey vs. Post-Survey Attitudes Score	0.32	.50	0.10 - 0.53	3.05	22	.003
Pre-Survey vs. Post-Survey Clinical Preparedness Score	0.62	.89	0.23 - 1.00	3.32	22	.002

The primary limitation to this project was that not all health care workers of the unit were able to be trained within the allotted time frame. Several training sessions were impeded or canceled due to unanticipated staff callouts, emergent patient events, high unit acuity, or flu exposure. Although the results were statistically significant, the clinical significance of a comprehensively competent workforce would be far more valuable to LGBTQ+ patients by mitigating gaps in knowledge, attitudes, or clinical preparedness. Given the canceled training sessions, the relatively small sample size of this project may also limit the generalizability of the significant results. Another limitation may have been

social desirability bias or self-reporting bias, which may have led a participant to rate their knowledge, skills, and attitudes higher than reality to be viewed more favorably (see Bettergarcia et al., 2021); however, the surveys were de-identified and the results of this project demonstrated an improvement.

The project site historically did not provide focused LGBTQ+ cultural competency training to the health care workers of the inpatient child and adolescent psychiatry unit, which impeded the provision of high-quality, patient-centered, trauma-informed care to applicable patients. The doctoral project addressed a prominent gap in the project setting's mental health care workers' cultural competency by facilitating a more knowledgeable, inclusive, and clinically prepared workforce for a vulnerable subset of a marginalized population. Several participants asked for additional LGBTQ+ cultural competency training in the future, indicating that the health care workers of the project site were interested in further refining and building on their knowledge and skills.

The literature indicated that LGBTQ+ patients experience disproportionate barriers to sufficiently affirming and inclusive health care, especially in the current turbulent sociopolitical context regarding LGBTQ+ human rights. All health care settings should endeavor to proactively mitigate inequitable health care access and health disparities by resolving potential gaps and establishing high standards in LGBTQ+ cultural competencies among staff members. This project is important beyond the local site due to the findings that even health care workers with an abundance of health care experience and previous LGBTQ+ cultural competency training stand to improve their knowledge, attitudes, and skills.

Conclusions

The staff education program for multidisciplinary mental health care workers improved staff knowledge, attitudes, and clinical preparedness regarding the LGBTQ+ community, as evidenced by statistically significant increases in overall LGBT-DOCSS scores and each of the subscale scores. Participants reported the impact this project had on them and their appreciation of the training, especially in regard to learning about LGBTQ+ lived health care experiences and reviewing appropriate terminology. Because multiple mental health care workers at the practicum site were unable to participate in the education, I would recommend that all staff of health care settings be trained to prevent gaps in competent care. I would also recommend that a follow-up refresher training be provided to health care workers on a consistent basis. The implementation of interactive LGBTQ+ cultural competency training should be a standard practice across health care settings to ensure equitable and affirming health care experiences, normalize everyday actions of professional allyship, and promote positive health outcomes for the LGBTQ+ community. Health care workers must be made aware of their implicit biases and knowledge deficits regarding marginalized groups to better treat their patients.

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Appendix A: Learning Objectives

Learning Objective	Detailed Course Content	Sources of Evidence	Delivery Method(s)	Assessment Tools and Method(s)
By the end of module one, the learner will be able to understand and describe current terminology and inclusive vocabulary regarding the LGBTQ+ community	- Definitions - Acronyms - Spectrum of identity and orientation - Pronouns - Outdated language and discriminatory misconceptions - Inclusive terms	Bettergarcia et al. (2021) Bettergarcia et al. (2024) Boekeloo et al. (2024) DeCesaris et al. (2024) Donisi et al. (2020) Oblea et al. (2022) Schneidwind (2024) Nowaskie et al. (2024) Yu et al. (2023) Bishop et al. (2022)	Slides	LGBT-DOCSS item #3, 4, 5, 7, 9, 10, 11, 12, 17, 18
By the end of module two, the learner will be able to provide examples of prominent health disparities in the adolescent LGBTQ+ community, and apply knowledge to the unit's patient population	- Mental health disparities - Social determinants of health - Barriers to equitable and affirming psychiatric care	Bettergarcia et al. (2021) Bettergarcia et al. (2024) Boekeloo et al. (2024) DeCesaris et al. (2024) Donisi et al. (2020) Oblea et al. (2022) Nowaskie et al. (2024) Yu et al. (2023) Rhoten et al. (2022)	Slides Discussion	LGBT-DOCSS item #1, 2, 4, 5, 6, 8, 9, 10, 11, 18
By the end of module three, the learner will analyze the unit's current care practices through the lens of evidence-based theoretical frameworks	- Minority stress theory - Intersectionality framework - Trauma-informed care model - Patient-centered care model - Cultural humility	Bettergarcia et al. (2021) Bettergarcia et al. (2024) Boekeloo et al. (2024) DeCesaris et al. (2024) Donisi et al. (2020) Schneidwind (2024) Nowaskie et al. (2024) Yu et al. (2023) Bishop et al. (2022)	Slides Discussion	LGBT-DOCSS item #1, 2, 6, 8, 10, 11, 13, 18
By the end of module four, the learner will critique healthcare practices based on LGBTQ+ individuals' lived experiences	- Testimonial videos from LGBTQ+ individuals - Poll results from the Trevor Project	Bettergarcia et al. (2021) Schneidwind (2024) Yu et al. (2023) Bishop et al. (2022)	Videos Slides Discussion	LGBT-DOCSS item #4, 10, 11, 13, 14, 15, 16, 18
By the end of module five, the learner will identify practical applications of the content and opportunities for clinical advocacy	- Affirming practice - Advocacy - Allyship	Bettergarcia et al. (2021) Boekeloo et al. (2024) Donisi et al. (2020) Oblea et al. (2022) Schneidwind (2024) Yu et al. (2023) Rhoten et al. (2022) Bishop et al. (2022)	Slides Discussion Skill rehearsal	LGBT-DOCSS item #4, 10, 11, 13, 14, 15, 16, 18

Appendix B: Pre-Survey

Pre-Training Survey

Instructions: All data collected will be anonymous, no individual's information will be given to unit leadership, and outcomes will be reported only in aggregate. Participant codes are needed solely to match pre-training and post-training scores on the scale in the next section. Please fill out the following demographic questions.

1. Participant code:

(The first four numbers of your employee ID, and the first letter of your home address → Ex. 2481N)

2. Age range (circle one):

25 or younger 26 - 35 36 - 45 46 - 55 55 or older

3. Healthcare role:

4. Years of experience in healthcare (circle one):

Less than 1 year 1 - 5 years 5 - 10 years 10 - 20 years Over 20 years

5. Have you ever received LBGTQ+ cultural competency training prior to today?

Instructions: Items on this scale are intended to examine clinical preparedness, attitudes, and basic knowledge regarding lesbian, gay, bisexual, and transgender (LGBT) clients/patients. Please rate your level of agreement or disagreement with each statement.

1. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

2. I am aware of institutional barriers that may inhibit LGB people from using health services.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

3. I think being transgender is a mental disorder.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

4. I would feel unprepared talking with a LGBT client/patient about issues related to their sexual orientation or gender identity.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

5. A same sex relationship between two men or two women is not as strong and committed as one between a man and a woman.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

6. I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

7. LGB individuals must be discreet about their sexual orientation around children.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

8. I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to cisgender individuals.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

9. When it comes to transgender individuals, I believe they are morally deviant.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

10. I have received adequate clinical training and supervision to work with transgender clients/patients.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

11. I have received adequate clinical training and supervision to work with lesbian, gay, and bisexual (LGB) clients/patients

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

12. The lifestyle of a LGB individual is unnatural or immoral.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

13. I have experience working with LGB clients/patients.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

14. I feel competent to assess a person who is LGB in a therapeutic setting.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

15. I feel competent to assess a person who is transgender in a therapeutic setting.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

16. I have experience working with transgender clients/patients.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

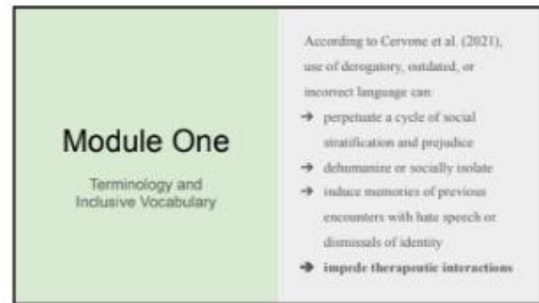
17. People who dress opposite to their biological sex have a perversion.

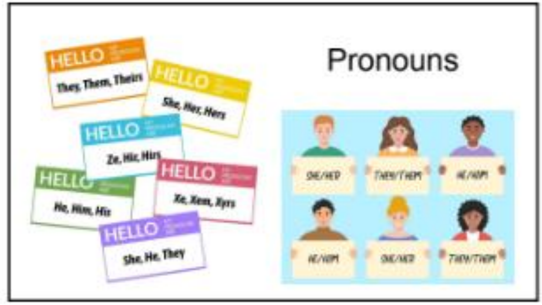
Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

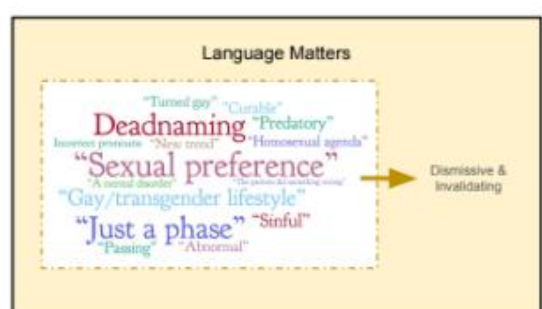
18. I would be morally uncomfortable working with a LGBT client/patient.

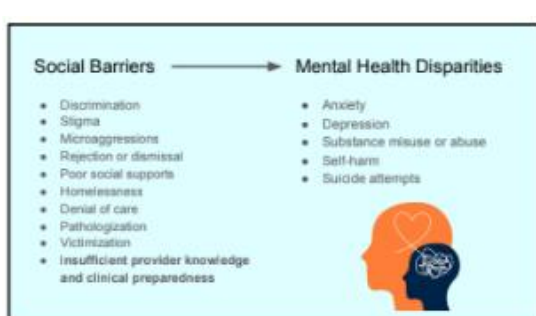
Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

Appendix C: Course Content









Module Three

Theoretical Frameworks to Guide Patient-Centered Practice

By facilitating knowledgeable healthcare professionals and normalizing affirming, inclusive clinical practices, healthcare systems can advance health equity and patient-centered care for LGBTQ+ patients (Ripley-Hager & Schlussel, 2025).

Trauma-Informed Care

Offering trust, collaboration, empowerment, and autonomy within the healthcare environment can counteract damaging effects of trauma/prolonged stress, and promote resilient recovery.

Realize → Recognize → Respond → Resist Re-traumatization

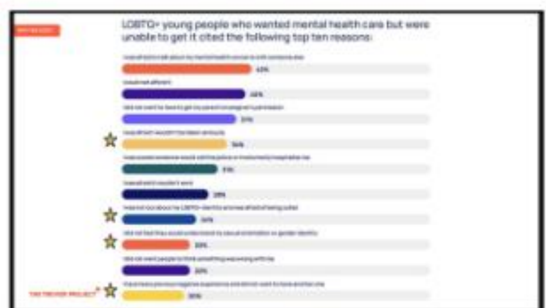
Cultural Humility

All social interactions can benefit from openness to individuals' sociocultural backgrounds and identities.

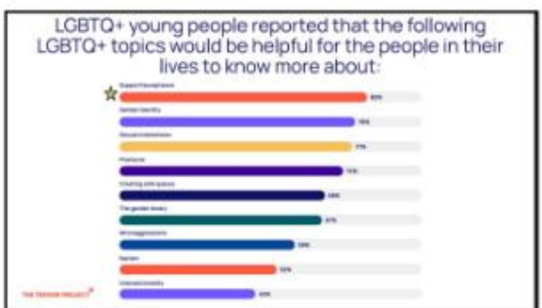
Healthcare professionals should:

- engage in continuous learning and self-reflection
- avoid generalizations or assumptions
- be receptive to feedback
- prioritize individual patients' experiences, values, perspectives, and needs

Module Four
Lived Experiences
Hearing, reading, or being familiar with LGBTQ+ individuals' lived experiences is the best way to improve knowledge and attitudes regarding the LGBTQ+ community (Bishop et al., 2022)



LGBTQ+ young people who wanted mental health care but were unable to get it cited the following top ten reasons:

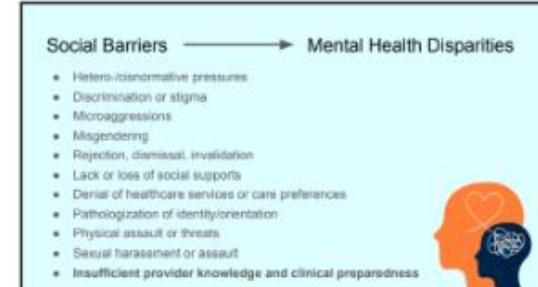


LGBTQ+ young people reported that the following LGBTQ+ topics would be helpful for the people in their lives to know more about:

Discussion:
Do you have any take-aways from these individuals' experiences?

Module Five
Practical Applications and Advocacy

Your communication and practice can mitigate health disparities for LGBTQ+ adolescents.



Examples of Affirming Practice:

- ☆ Establish the patient as the expert
- Ask about preferred pronouns and preferred names
- Mirror the language used by the patient
- Use open-ended and respectful questions
- Practice active, empathetic listening
- Adapt to the client's feedback and pace
- Encourage self-care & self-acceptance
- Incorporate the patient's chosen support system

Examples of Advocacy & Allyship

- ☆ Continually learn
- ☆ Self-reflect
- Normalize pronouns
- Practice gender-neutral language
- Maintain a nonjudgmental attitude
- Correct colleagues, peers, and the public
- Foster an inclusive environment
- Support LGBTQ+ inclusion in non-discrimination policies
- Expand affirming and peer support resources
- Support LGBTQ+ representation in the media
- Follow advocacy groups and supportive organizations
- Attend community events and trainings

Appendix D: Allyship Handout

A HEALTHCARE WORKER'S GUIDE *to being an* ALLY

ACT · LEARN · LISTEN · YIELD

An Ally is *someone who confronts biases in themselves and others, has concern for the well-being of LGBTQIA+ individuals, and believes bias and discrimination are social justice issues.* **Healthcare Workers** *have a special obligation to advocate for all patients, especially those who experience more significant health disparities and injustices.*

THE ALLYSHIP TOOLBOX

Read, research and educate yourself
Speak up for others
Always self-reflect
Confront your own biases
Lift up others by advocating
Respond with empathy
Have open dialogues
Hold others & ourselves accountable

1. **Use the right words.**
   Use inclusive, non-gendered language ("patient," "partner/spouse," use "they/them" until you can confirm preferred pronouns). *Never assume*; gender expression does not equal gender identity. Ask and document preferred pronouns and chosen name.
2. **Continue to educate yourself.**
   Laws and language are constantly changing. Be aware of health disparities in LGBTQIA+ populations. Know resources for patients and families. Effective allyship is not a consequence of good intentions; it is *a skill that must be taught*.
3. **Identify yourself as an ally and create a supportive and safe environment.**
   Wear an ally or rainbow pin or sticker. Display your pronouns. Post "safe space" signage. Speak up if you see someone experiencing discrimination. Challenge prejudiced jokes or remarks. Correct colleagues on misuse of pronouns or preferred names. *Be a role model* for others by being visible in your support and open to talk about disparities and injustices.
4. **Listen and Yield.**
   While you can use your *privilege* to amplify suppressed voices, allyship is based on yielding dialogue to those with different lived experiences. Listen to others and give them time, space, and attention.

N.McFarland 2024

Appendix E: Post-Survey

Post-Training Survey

Instructions: All data collected will be anonymous, no individual's information will be given to unit leadership, and outcomes will be reported only in aggregate. Participant codes are needed solely to match pre-training and post-training scores on the scale in the next section.

1. Participant code:

(The first four numbers of your employee ID, and the first letter of your home address → Ex. 2481N)

2. What did you find to be most helpful or impactful from the training?

3. How could the training be improved or more useful?

Instructions: Items on this scale are intended to examine clinical preparedness, attitudes, and basic knowledge regarding lesbian, gay, bisexual, and transgender (LGBT) clients/patients. Please rate your level of agreement or disagreement with each statement.

1. I am aware of institutional barriers that may inhibit transgender people from using health care services.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

2. I am aware of institutional barriers that may inhibit LGB people from using health services.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

3. I think being transgender is a mental disorder.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

4. I would feel unprepared talking with a LGBT client/patient about issues related to their sexual orientation or gender identity.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

5. A same sex relationship between two men or two women is not as strong and committed as one between a man and a woman.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

6. I am aware of research indicating that LGB individuals experience disproportionate levels of health and mental health problems compared to heterosexual individuals.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

7. LGB individuals must be discreet about their sexual orientation around children.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

8. I am aware of research indicating that transgender individuals experience disproportionate levels of health and mental health problems compared to cisgender individuals.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

9. When it comes to transgender individuals, I believe they are morally deviant.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
1	2	3	**4**	5	6	**7**

10. I have received adequate clinical training and supervision to work with transgender clients/ patients.

Strongly Disagree			Somewhat Agree/Disagree			Strongly Agree
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